Cornerstone Counseling Services, Inc.

Authorization for Use and Release of Patient-Identifiable Health Information

Individual/Patient/Client/Insured:

_____ _____ _____

Name of Individual | Previous Name(s) | Birth Date

_____ _____(_____)_____

Street Address | City, State, Zip, Phone

AUTHORIZES DISCLOSURE OF PROTECTED HEALTH INFORMATION BY AND BETWEEN:

_____	Cornerstone Counseling/ .
Individual(s)/agency/organization making disclosure and/or receiving information	Individual(s)/agency/organization making disclosure and/or receiving information
_____	16535 W. Bluemound Road, Suite 200 .
Street Address	Street Address
_____	Brookfield, WI 53005 .
City, State, Zip Code	City, State, Zip Code
_____	Ph# 262-789-1191 Fax# 262-821-6180 .
Phone Number, Fax Number	Phone Number, Fax Number

INFORMATION TO BE USED and/or DISCLOSED:

The following is a specific description of the health information I authorize to be used and/or disclosed _____

_____

In compliance with applicable law, which require special permission to release otherwise privileged information please release records pertaining to: (Check all that apply)

☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol and/or Drug Abuse ☐ HIV test results

☐ Other (specify): _____

For the following date(s): From _____ To _____.

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

☐ Further Medical Care ☐ Coordinating Care for Dependent/Spouse ☐ Insurance Eligibility /Benefits ☐ Claims Resolution

☐ At the request of the individual ☐ Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: **Right to Receive Copy of This Authorization** – I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and that Cornerstone may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization**. Right to Revoke This Authorization** – I understand that I have the right to revoke this authorization at any time by providing a written statement of revocation to Cornerstone and/or a medical records/health information department. I am aware that any revocation will not be effective until received by Cornerstone and will not be effective regarding the uses and/or disclosures of my health information that Cornerstone has made prior to receipt of my revocation statement. I understand that the revocation will not apply to my insurance company (if applicable) when the law provides my insurer with the right to contest a claim under my policy. **Marketing** – I understand if Cornerstone uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information. **Right to Inspect or Copy the Health Information to Be Used or Disclosed** – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form, to the extent allowed by law and Cornerstone. I may arrange to inspect such health information or obtain copies thereof by contacting Cornerstone.

RE-DISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event) _____

_____. If no date, event or condition is indicated, this authorization will expire (1) year following the date of signature. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE of PATIENT/LEGAL REPRESENTATIVE: _____ DATE: _____

If signed by other than individual, state relationship or legal authority: _____